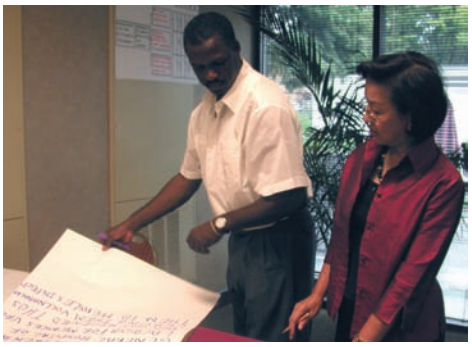
Sustainable Management Development Program Annual Report 2005

to the CDC Global AIDS Program








Sustainable Management Development Program
Office of Capacity Development and Program Coordination
CDC Coordinating Office for Global Health
www.cdc.gov/smdp

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The Sustainable Management Development Program (SMDP)

Since 1992, CDC's SMDP has worked in 61 developing countries with public and private sector donors to strengthen management training capacity within Ministries of Health, non-governmental organizations (NGOs), and academic institutions. SMDP partners with Emory University and private sector faculty to offer each fall in Atlanta a 6-week Management for International Public Health (MIPH) training course for management trainers.

The MIPH course provides participants with practical skills they need to manage and lead effective public health organizations and to teach those skills to others. Training modules in 2005 included advocacy, conflict resolution, designing and delivering training, donor relations, leading organizational change, leadership, marketing, media relations, organizational excellence, presentation skills, program planning and project management, strategic communication, supervision, team building, and Total Quality Management (TQM). The MIPH course curriculum is based on a set of core competencies for public health managers which is described more fully on SMDP's website (http://www.cdc.gov/smdp/corecomp.htm).

After completing the MIPH course, graduates return to their countries to implement public health management training for public health professionals in a variety of institutions. One of the unique features of SMDP-affiliated training at the country level is a requirement for all local participants to complete an *applied management learning project* that helps translate classroom knowledge into the ability to solve real public health management problems in the workplace.

To date, SMDP has trained 293 trainers from 61 countries in the MIPH course. These trainers in turn have trained more than 3,000 public health professionals. Specific programs that have benefited from improved management capacity include immunizations, tuberculosis, malaria, onchocerciasis, reproductive health, and HIV/AIDS.

SMDP Collaboration with the CDC Global AIDS Program (GAP)

Soon after GAP deployed field staff in early 2000, SMDP began receiving requests to provide public health management training to GAP's local counterparts. From 2000 to 2002, the number of GAP-sponsored participants attending the 6-week MIPH course in Atlanta quadrupled, from three in 2000 to 12 in 2002. As MIPH graduates returned home, GAP field staff and MIPH alumni asked SMDP to provide technical assistance to help establish in-country training programs to address local management training needs.

In 2003, CDC's National Center for HIV, STD and TB Prevention and the former Public Health Practice Program Office signed a Memorandum of Understanding that provided funds for SMDP to support up to seven GAP-focus countries per year. Additional financial support for in-country management training and technical assistance comes from GAP field offices. Since 2003, SMDP has helped GAP establish management training programs in Botswana, Malawi, Thailand, Uganda, Vietnam, and Zambia. GAP-focus countries in the early stages of developing training programs include Ethiopia, Haiti, India, Lesotho, Mozambique and Swaziland.

Leading the effort to establish in-country programs are 63 local counterparts of GAP field staff from 15 countries who have completed SMDP's MIPH course since 2000. These trainers have subsequently trained hundreds of local laboratory, HIV/AIDS and TB program managers from GAP-focus countries, including 172 managers trained in 2005. Since 2003, SMDP staff have made 44 technical assistance visits to GAP-focus countries to assist with the establishment of training programs for these managers.

This report summarizes the progress towards strengthening public health management training capacity in GAP-focus countries as of 2005. The table on page 5 summarizes the outputs of SMDP and GAP's collaborative efforts in 2005 to strengthen the management skills of public health managers in these countries.

About this Report

In the following sections of this report, management development activities are summarized by country and each section describes in-country public health management training organized by MIPH alumni.

To help link the impact of the management training to GAP program goals, the country summary tables show how the results of the applied management learning projects align with GAP technical strategy areas.* The report has four appendices. Appendix A outlines SMDP's criteria for three levels of training program development and notes representative country programs at each level. Appendix B lists SMDP's guiding

*CDC/GAP Indicator Guide for Annual Reporting 2004, Version 3

principles. Appendix C contains a synopsis of applied management learning projects completed by participants from three in-country training programs. Appendix D consists of a list of MIPH graduates in the eight countries covered in this report, noting which graduates were sponsored by GAP.

The work described in this report represents the efforts of many individuals, each of whom played an important role in helping to achieve a shared vision of providing high quality public health services, managed and led by competent, capable personnel. We thank them for their efforts, and pledge our continuing support.

In-Country Training Program Results

Summary of SMDP In-Country Training Programs in GAP Countries Jan-Dec 2005

Country	No. Managers Trained In-Country	Target Audiences for Training	Collaborating Institutions	No. Applied Management Learning Projects
Botswana	22	HIV/AIDS program managers	BOTUSA, Institute for Development Management, CDC Global AIDS Program (GAP)	18
Haiti	0	Local HIV/AIDS program managers, data clerks and data managers	GAP Haiti	0
India	22	HIV/AIDS project managers, volunteers	Indian Network for People Living with HIV/AIDS (INP+), GAP India	0
Malawi	34	TB and HIV/AIDS program managers	National TB Programme, Malawi AIDS Counseling and Resource Organization, Infection Control Programme, Ministry of Health, GAP Malawi	9
Thailand	24	Medical technologists	Thai National Institute of Health, MOPH, Mahidol University, Thai-MOPH CDC Collaborative (TUC), and GAP Thailand	5
Uganda	0	Public health managers, laboratory technicians and managers, public health graduate students	Institute of Public Health, Makerere University, GAP Uganda	0
Vietnam HIV/AIDS	70	HIV/AIDS program managers	Hanoi School of Public Health, GAP Vietnam	22
Zambia	0	Medical technologists, laboratory managers	Central Board of Health, Ministry of Health, GAP Zambia	0
Total # of managers trained:	**172**		**Total # of applied management learning projects:**	**54**

Country Summaries

Botswana

Botswana: Program Background		
Start date:	September 2001	
Current state of development:	Advanced	
Institutional counterpart:	Institute of Development Management	
Date in-country training began:	June 2003	
Target audience:	Local HIV/AIDS program managers	
SMDP Activities	**2005**	**Cumulative**
Technical assistance visits:	2	7
GAP-sponsored MIPH graduates:	1	6
Completed cyles in-country training:	1	3
In-country managers trained:	22	56
In-country person training days *(# managers trained x # training days):*	264	604
Number of applied management learning projects:	18	47
GAP technical strategies supported by the applied management learning projects (see App C, pp. 24-30)		
Counseling and testing	4	20
Youth	1	2
Public-private partnerships/workplace programs	4	6
Care and treatment	4	6
Laboratory support	2	5
Health information systems	2	6
Other	1	2

MIPH 2005 alumna Rose Choto, Institute of Development Management, carries out an exercise during Healthy Plan-it™ training in the annual MIPH course.

SMDP's partners in Botswana include BOTUSA, a collaborative effort between CDC-GAP and the government of Botswana to combat HIV/AIDS, and the Institute of Development Management (IDM), a regional organization that conducts training, consulting, and research in Botswana, Lesotho, and Swaziland. BOTUSA employs one MIPH graduate; IDM, five. BOTUSA, IDM, and SMDP are working together to strengthen the management skills of public health program managers and staff in Botswana.

With BOTUSA sponsorship, IDM coordinated an initial 2-week Botswana management training workshop in Gaborone in June 2003. Fifteen HIV/AIDS program managers from various NGOs, community-based organizations, and governmental agencies learned about Total Quality Management (TQM), team building, leadership, Healthy Plan-*it*™, communication skills, patient flow analysis, and monitoring/evaluation. The participants then returned to their worksites and formed quality improvement teams to address HIV/AIDS-related work process problems. They presented their project results in November 2003 at the end of a final week-long workshop that also covered budgeting, marketing, and project management. In 2004, a second cohort of program managers proceeded through this management training cycle. Teams in the first two years completed 29 HIV/AIDS-related applied management learning projects.

In 2005, a third cohort of program managers was trained in TQM during a two-week workshop conducted primarily by IDM consultants and MIPH alumni with minimal assistance from SMDP. Participants included laboratory technologists, pharmaceutical technicians, social scientists, nursing practitioners, informatics specialists and NGO staff members. The 18 projects improved organizational performance in such areas as decreasing patient waiting time for prescriptions at a hospital pharmacy, increasing the number of HIV counseling sessions held, improving turnaround time for specimens in a hospital laboratory, improving sputum collection from tuberculosis patients, and improving adherence to treatment among mentally ill patients in a government hospital.

BOTUSA hired an independent consultant to conduct a mid-term evaluation of the training program to provide feedback to BOTUSA, IDM, and SMDP toward improving the Botswana management training course. Specific evaluation recommendations included these:

- Increase the amount of time provided for teams to complete their applied management learning projects.
- Conduct a comprehensive summative impact study at some point in the future.
- Maintain the team-based problem-solving approach advocated in the management training program, “because it is in line with the consensus ethical culture of Batswana.”
- Establish the management training program as one of IDM’s permanent in-service training programs.
- Establish a database for the in-country participants so that they can share information and learning points.
- Conduct activities to encourage the program’s sustainability, especially the following: a TQM refresher course for in-country course graduates; a dissemination seminar for stakeholders, senior management and political lead ers; a refresher train-the-trainer work shop for facilitators and supervisors; and a workshop or consultancy to review and standardize teaching materials.
- Market the program widely in Botswana.

Standing: MIPH 2001 graduate Martin Mosima and Tebatso Paul (’04), both with IDM, consult with TQM workshop participants (seated) on a countermeasures matrix for an applied management learning project.

Haiti

Haiti: Program Background	
Start date:	September 2004
Current state of development:	Beginning
Institutional counterpart:	GAP Haiti
Date in-country training began:	March 2005
Target audience:	Local HIV/AIDS program managers, data managers

SMDP Activities	2005	Cumulative
Technical assistance visits:	0	1
GAP-sponsored MIPH graduates:	2	4
Completed cyles in-country training:	0	0
In-country managers trained:	0	0
In-country person training days *(# managers trained x # training days):*	0	0
Number of applied management learning projects:	0	0

In 2003, the Global AIDS Program (GAP), in collaboration with USAID, began supporting the rapid start-up of a nationwide network of 40 centers for voluntary counseling and testing (VCT) and treatment to prevent mother-to-child HIV transmission. CDC also established 10 specialized centers for comprehensive care and treatment of HIV-infected persons. SMDP was invited to undertake an initial assessment and planning visit in December 2003, and targeted several possible participants for the MIPH course in 2004, especially from NGO partners. In Haiti, NGOs play a major role in providing health services.

A physician from the Ministry of Public Health and a nurse educator from GHESKIO (Groupe Haitien d'Etudes du Sarcome de Karposi et des Infections Opportunistes) graduated from the 2004 MIPH course.

In 2005, MIPH graduates included an advocate with the Association for National Solidarity (ASON)—an information and advocacy group for those infected with and affected by HIV/AIDS, and the Director of Information and Communication from Zanmi Lasante—an organization that works with NGO Partners in Health to operate full service medical centers in Haiti in partnership with the Ministry of Health. The MIPH graduate from Zanmi Lasante developed and conducted two workshops to help data clerks and data managers at Zanmi Lasante to use electronic medical records to collect, analyze, and generate reports on HIV and TB patients. These electronic reports are required by the Global Fund Against AIDS, TB, and Malaria (GFATM) and the U.S. President's Emergency Plan for HIV/AIDS Relief (PEPFAR).

India

India: Program Background		
Start date:	September 2004	
Current state of development:	Beginning	
Institutional counterparts:	Indian Network for People Living with HIV/AIDS (INP+)	
Date in-country training began:	December 2004	
Target audience:	Local HIV/AIDS program managers	
SMDP Activities	**2005**	**Cumulative**
Technical assistance visits:	0	1
GAP-sponsored MIPH graduates:	0	2
Completed cyles in-country training:	1	2
In-country managers trained:	22	36
In-country person training days *(# managers trained x # training days):*	44	104
Number of applied management learning projects:	0	1
GAP technical strategies supported by the applied management learning projects		
Public-private partnerships/ Workplace programs	0	1

SMDP's partners in India are GAP India and the Indian Network for People Living with HIV/AIDS (INP+). GAP India sponsored two participants to attend the MIPH 2004 course, one each from GAP and INP+.

The two MIPH 2004 graduates organized the first Healthy Plan-*it*™ program management workshop for 14 INP+ project managers, in Chennai, the capital city of Tamil Nadu state, upon their return. These MIPH graduates were assisted during the 4-day workshop by the MIPH 2001 graduate from LAICO-ARAVIND Eye Care System and by SMDP staff. Four of the 14 trained INP+ project managers assumed responsibility for conducting Healthy Plan-*it*™ training for several other groups, including 10 District Level Network (DLN) leaders and 12 community-based PLWHA peer educators in three districts. These PLWHA educators are key to the work of INP+, because they conduct support group meetings and represent the HIV-positive members and their families in times of need.

*Photo above: INP+ workshop participants carry out a team-building exercise during the Healthy Plan-*it™ *program management workshop, in Chennai, Tamil Nadu.*

The leaders of two HIV/AIDS community organizations in one of the districts, Guntur, joined forces to create a sustainable plan and they then approached the district government for funding and support for an employment intervention for women infected with or affected by HIV/AIDS.

Future Plans

The MIPH 2004 graduate from GAP India plans to conduct a workshop on leadership and team building for INP+ managers in spring 2006. In addition, INP+ has requested Healthy Plan-*it*™ workshops for other DLNs, and Tambaram Hospital's CDC-sponsored Medical Graduate Fellowship program has requested management training.

Malawi

Malawi: Program Background		
Start date:	September 2002	
Current state of development:	Intermediate	
Institutional counterparts:	National TB Programme, Malawi AIDS Counseling and Resource Organization, Infection Control Programme (ICP), MOH	
Date in-country training began:	February 2003	
Target audience:	Local TB and HIV/AIDS program managers, VCT counselors	
SMDP Activities	**2005**	**Cumulative**
Technical assistance visits:	2	8
GAP-sponsored MIPH graduates:	3	8
Completed cyles in-country training:	1	3
In-country managers trained:	34	103
In-country person training days *(# managers trained x # training days):*	216	670
Number of applied management learning projects:	9	21
GAP technical strategies supported by the applied management learning projects (see App C, pp. 31-34)		
Counseling and testing	3	3
Tuberculosis prevention and care	6	19

Photo at left: Knox Banda, Laboratory Technician, Nkhata Bay District Hospital, and Edith Chimutu, MACRO Blantyre, write countermeasures for a TQM exercise. Photo at right: Tamara Phiri, MACRO Lilongwe, reviews the countermeasures matrix for her group.

SMDP's partners in Malawi include GAP Malawi, the National TB Programme (NTP), the Malawi AIDS Counseling and Resource Organization (MACRO), and the Infection Control Program (ICP) of the Ministry of Health. To date, 10 trainers from Malawi have graduated from the MIPH course—eight of them sponsored by GAP.

The first management training workshop in 2003 for 35 TB program managers focused on TQM and leadership. Stakeholders added effective presentation skills to the curriculum for the second group of 34 TB program managers in 2004. Teams in the first two years completed 12 applied management learning projects to improve work processes on a variety of TB and HIV/AIDS-related topics.

In January 2005, Malawi MIPH course graduates and SMDP staff co-facilitated a one-week workshop on TQM and leadership for the third management training cycle. The third cohort consisted of 34 participants comprising seven teams—four TB program managers each from seven district hospitals plus three teams of two senior counselors each from three MACRO sites. Their applied management learning projects reported positive impact on improving such problems as low case-detection for smear-positive TB patients, insufficient quality control for HIV counseling and testing, and overly lengthy HIV counseling sessions. See Appendix C for a summary of all nine applied management learning projects.

Thailand

Thailand: Program Background	
Start date:	September 2003 - GAP September 1993 - MOPH
Current state of development:	Beginning
Institutional counterparts:	National Institute of Health, Ministry of Public Health, Thai MOPH-CDC Collaborative (TUC), Mahidol University
Date in-country training began:	May 2005
Target audience:	Medical technologists

SMDP Activities	2005	Cumulative
Technical assistance visits:	3	4
GAP-sponsored MIPH graduates:	4	6
Completed cyles in-country training:	1	1
In-country managers trained:	24	24
In-country person training days *(# managers trained x # training days):*	120	120
Number of applied management learning projects:	5	5
GAP technical strategies supported by the applied management learning projects (see App C, pp 35-36)		
Laboratory support	4	4
Tuberculosis prevention and care	1	1

In 2004, officials from the Thai National Institute of Health (NIH) and the Ministry of Public Health (MOPH) expressed interest in establishing a management training program modeled on the Philippines Laboratory Management Training Program. Since then, a 2003 MIPH graduate from Mahidol University (MU) has worked with SMDP to establish a Thai Sustainable Management Training Center (SMTC). Institutional partners now include the MOPH, MU, the NIH and the Thai-MOPH CDC Collaborative (TUC). A four-person team representing all four institutions attended the 2005 MIPH course and is now assisting with the program.

The five MIPH graduates co-taught an initial SMTC Total Quality Management (TQM) course in May 2005 to 24 medical technologists representing eight hospital labs, one regional medical center, and the NIH. Results of three of their five applied management learning projects are summarized below:

- The percent of acid-fast bacillus smears for TB testing that exceeded the 40-minute standard in Mae Lao and Mae Suai Hospital was reduced from 50% to 16% (12/75).
- In Phayao Hospital, the percent of patients waiting longer than normal was reduced from 82% to 49%, thus enabling hospital staff to provide service to at least 20 more patients per day on average.
- At Rachaburi Hospital, the average blood specimen processing time was cut by 45%, from 83 to 46 minutes.

The remaining projects will be completed in June 2006.

Future Plans

Hold a second TQM workshop in 2006 for public health practitioners from the rural provinces of Lopburi, Nakhonsawan, and Pittsanulok and from the central province of Nonthaburi, assisted by SMDP staff.

Medical and public health personnel of Lopburi and Phitsanuloke provinces work on a countermeasure activity during the second SMTC workshop.

Uganda

Uganda: Program Background		
Start date:	September 2002	
Current state of development:	Intermediate	
Institutional counterpart:	Institute of Public Health, Makerere University,	
Date in-country training began:	May 2003	
Target audience:	Public health managers, laboratory technicians and managers, public health graduate students	
SMDP Activities	**2005**	**Cumulative**
Technical assistance visits:	1	7
GAP-sponsored MIPH graduates:	1	3
Completed cyles in-country training:	0	2
In-country managers trained:	0	41
In-country person training days *(# managers trained x # training days):*	0	396
Number of applied management learning projects:	0	16

SMDP partners in Uganda include GAP Uganda and the Institute of Public Health (IPH), Makerere University. In 2002, three Ugandans attended the MIPH course. These public health professionals came from the National TB Programme, the Uganda Viral Research Institute (UVRI), and the STD/AIDS Programme in the Ministry of Health. In 2003, the Institute of Public Health (IPH) became the institutional home of the public health management training program. Two persons from the IPH/CDC HIV Fellowship Program, including the fellowship coordinator, attended the MIPH course in 2003.

In 2005, MIPH graduates from the Makerere University IPH taught Healthy Plan-*it*™ to the annual cohort of IPH/CDC HIV Fellows. The fellows developed project plans for priority programs in their host institutions. In July 2005, a Ugandan MIPH graduate from IPH was invited to facilitate the first public health management module to 2005 participants in the CDC-sponsored Field Epidemiology and Laboratory Training Program in Nairobi, Kenya.

CDC Uganda sponsored two participants to the 2005 MIPH course, a laboratory manager and a trainer with the HIV Reference Laboratory, Uganda Virus Research Institute. They plan to implement management modules within laboratory training scheduled during 2006.

Kenyan masters degree candidates in laboratory management and epidemiology learn public health management and leadership skills from MIPH 2004 graduate Dr. Elizeus Rutebemberwa of Uganda, Makerere University Institute of Public Health (seated). Also pictured is Anisa Kassim of SMDP.

Vietnam HIV/AIDS

Vietnam HIV/AIDS: Program Background		
Start date:	September 2004	
Current state of development:	Beginning	
Institutional counterpart:	Hanoi School of Public Health	
Date in-country training began:	July 2005	
Target audience:	HIV/AIDS program managers	
SMDP Activities	**2005**	**Cumulative**
Technical assistance visits:	4	4
GAP-sponsored MIPH graduates:	2	6
Completed cyles in-country training:	1	1
In-country managers trained:	70	70
In-country person training days *(# managers trained x # training days):*	350	350
Number of applied management learning projects:	22	22
GAP technical strategies supported by the applied management learning projects		
Counseling and testing	13	13
Care and treatment	8	8
Health information systems	1	1

In 2004, the CDC Global AIDS Program (GAP) partnered with the Hanoi School of Public Health (HSPH) to enhance public health capacity for HIV prevention and care. A new 5-year agreement between GAP and the HSPH has three objectives: 1) a decentralized self-sustaining HIV/AIDS management training program, 2) a data-management system for U.S. government HIV/AIDS programs in Vietnam, and 3) an overarching HIV/AIDS strategy for the HSPH. To address the first objective—creating a decentralized self-sustaining HIV/AIDS management training program—three training centers were established: one in the HSPH in Hanoi for the north, a second in the Preventive Medical Center in Danang for the central region, and a third in the Institute for Hygiene and Public Health in Ho Chi Minh City (HCMC) for the south of Vietnam. All three training centers—in Hanoi, Danang, and HCMC—will provide management training workshops for HIV program managers in their regions.

In July 2005, three HSPH faculty who graduated from MIPH in 1997 and SMDP staff facilitated a two-week Training-of-Trainers (ToT) workshop in Hanoi focusing on Total Quality Management (TQM) and effective training techniques for HCMC and Danang public health personnel. The primary goal of the training is to enhance public health management capacity for HIV/AIDS prevention and care activities in Vietnam. Twenty-three participants from five institutions attended the ToT course and then carried out six applied management learning projects that dealt with work processes such as receiving samples in laboratories and processing rapid HIV tests. The leaders of the program from Danang Preventive Medical Center and HCMC Institute for Hygiene and Public Health also attended the 2005 MIPH course.

Since July 2005, the 23 participants who completed the July ToT facilitated TQM workshops in all three training centers. These TQM workshops reached 70 provincial HIV program managers from 24 provinces across the country. Graduation workshops at all three training centers for the partici-

pants of the regional TQM workshops are planned in the first half of 2006. A national HIV management training conference planned for July 2006 will give all participants of the TQM workshops the chance to present their best applied management learning projects. The second cycle of regional TQM workshops will begin at all three training centers in the fall of 2006.

Three regional TQM workshops were held in Vietnam. Photo above left, a team in Danang works on an exercise; photo above right: a team in the Hanoi TQM workshop. Photo at right: TQM instructor Dr. Sunny Nhat (MIPH '05) answers participants' questions during the workshop in Ho Chi Minh City.

Zambia

Zambia: Program Background	
Start date:	September 2001
Current state of development:	Intermediate
Institutional counterpart:	Central Board of Health, Ministry of Health
Date in-country training began:	March 2003
Target audience:	Medical technologists, laboratory managers

SMDP Activities	2005	Cumulative
Technical assistance visits:	0	5
GAP-sponsored MIPH graduates:	1	7
Completed cyles in-country training:	0	1
In-country managers trained:	0	26
In-country person training days *(# managers trained x # training days):*	0	286
Number of applied management learning projects:	0	18
GAP technical strategies supported by the applied management learning projects		
Laboratory support	0	18

SMDP's partners in Zambia include CDC's Global AIDS Program (GAP) in Zambia and Zambia's Central Board of Health and Ministry of Health. Laboratory managers and medical technologists representing all nine provinces participated in the first management training in 2003. The participants' applied management learning projects addressed such issues as late presentation of malaria test results and improperly fixed biopsy tissues. In 2004, an overview of the Zambian laboratory management training initiative was presented at SMDP's second biennial conference in Hanoi, Vietnam.

Two GAP-funded participants attended the 2004 MIPH course: a senior lecturer at Ndola College of Biomedical Science and the Director of Clinical Services at Ndola Central Hospital. In 2005, the seventh GAP-sponsored participant from Zambia attended MIPH: the Director of Clinical Care and Diagnostic Services in the Central Board of Health, Lusaka.

Planning began in 2005 for a management training course in Total Quality Management (TQM) for district HIV Voluntary Counseling and Testing laboratory personnel. The workshop will be conducted in August 2006. Participants will be involved in activities related to the President's Emergency Plan for AIDS Relief. Several MIPH graduates will co-facilitate this workshop and supervise the applied management learning projects the workshop participants will implement at their workplaces.

Dr. Velepi Mtonga, Central Board of Health, facilitates a TQM exercise during the MIPH 2005 course.

Appendices

Appendix A

Program Development Indicators

SMDP monitors the program development in each country using the indicators below to assess progress from early to advanced stages. In the early development stages, SMDP provides intensive training and project supervision support to new programs. As programs mature, MIPH alumni assume more responsibility for in-country training and supervision. At the most advanced level, programs serve as regional resources supporting the development of public health management training programs in other countries.

Program Development Indicators

Early Development	Intermediate Development	Advanced Program Development
☐ Completed <1 cycle of training and applied management learning projects	☐ Completed >1 cycle of training and applied management learning projects	☐ Completed >3 cycles of training and applied management learning projects
☐ 1-3 MIPH graduates	☐ 4-7 MIPH graduates	☐ >8 MIPH graduates
☐ MIPH alumni conduct <50% of training	☐ MIPH alumni conduct >50% of training	☐ MIPH alumni conduct 100% of training and supervisory follow-up
☐ SMDP planning and assessment visit completed	☐ Training work plan implemented	☐ Training work plan in 2nd or 3rd phase of implementation
	☐ Established funding mechanisms	☐ Established funding mechanisms and income-generating activities
	☐ Institutional home with at least part-time staff	☐ Institutional home with permanent staff and budget resources
	☐ >50% of applied management learning projects have measurable impact	☐ >80% of applied management learning projects have measureable impact
		☐ Program serves as a regional resource for public health management training
Examples: o Brazil o Haiti o Lesotho o Mozambique o Saipan o Serbia & Montenegro o Swaziland o Thailand	**Examples:** o Macedonia o Malawi o Mexico o Taiwan o Uganda o Vietnam/GAP o Zambia	**Examples:** o Botswana o Croatia o Guam o Philippines o Vietnam/TB

Appendix B

SMDP Guiding Principles

- Emphasize applied skills, not just theoretical knowledge.
- Train in a highly interactive manner and draw upon participants' personal experience to reinforce team learning.
- Incorporate public health examples to illustrate the use of management tools that may originally have been developed for industry or other sectors (e.g., TQM); keep examples relevant for developing country audiences.
- Provide numerous tips, practical aids, and tools that facilitate teaching the materials to others.
- Emphasize evidence-based decision-making in management.
- Use applied management learning projects to reinforce classroom learning, multiply training benefits, and generate products that have a measurable impact on public health program goals.
- Provide post-course technical assistance to support alumni teaching efforts.
- Solicit feedback through a variety of means (e.g., questionnaires, focus groups, external evaluations) and continuously strive to improve the content as well as the learning process.
- Provide post-training incentives such as website access, regional networking among alumni, conferences, fellowships, and career development opportunities to stimulate lifelong learning.

Appendix C

Applied Management Learning Projects

Botswana

Malawi

Thailand

Botswana Family Welfare Association (BOFWA), Maun

Problem: During the first 4 months of 2005, BOFWA in Maun had no monitoring & evaluation tool for outreach activities. This led to underreporting on activities, failing to meet donor requirements.

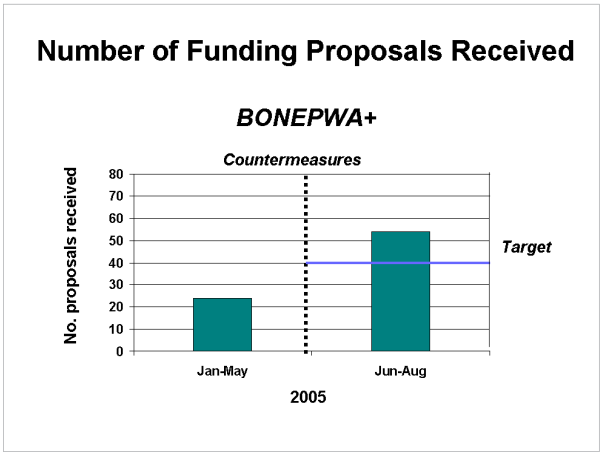
Improvement Target: Develop one monitoring & evaluation tool for outreach activities by August 5, 2005.

Countermeasures: 1) Hold a meeting to review all outreach activities, 2) develop an outreach tool.

Results: A monitoring & evaluation tool was in place by August 2005.

Botswana Network of People Living with HIV/AIDS (BONEPWA+)

Problem: In the first 5 months of 2005, only 24 of 80 (30%) affiliated support groups submitted their funding proposals to BONEPWA+ for HIV/AIDS intervention activities, thus resulting in low prevention and treatment of HIV/AIDS, and potential increases in HIV/AIDS.



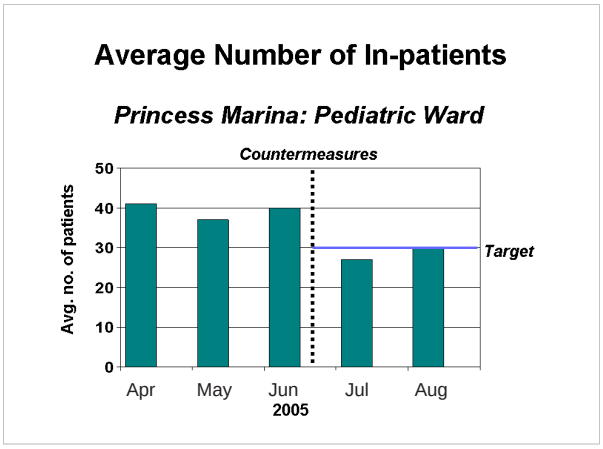
Improvement Target: Increase the number of funding proposals submitted from affiliated support groups to 40 of 80 (50%) during the period June to August 2005.

Countermeasures: 1) Develop a training manual, 2) hold a training workshop in use of the manual.

Results: Between June and August 2005, the number of proposals submitted was 54/80, or 68%, thus exceeding the 40 (50%) indicated in the target for improvement.

Princess Marina—Pediatric Ward

Problem: From April to June 2005, the average number of patients in the pediatric surgical ward exceeded by 9 the 30-bed capacity, thus compromising the quality of health care and creating consumer dissatisfaction.



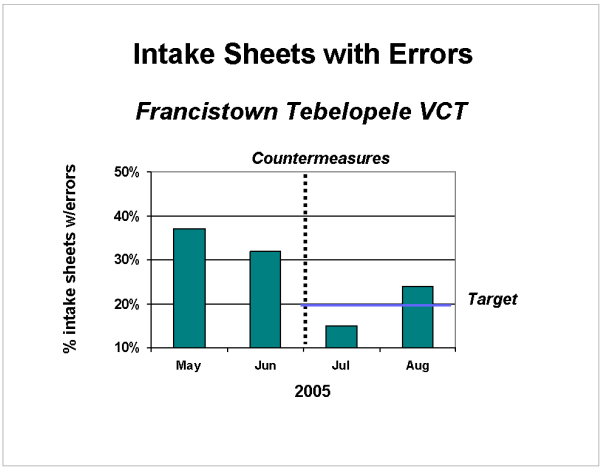
Improvement Target: Reduce the average number of patients above bed capacity from 9 to 0 during July and August 2005.

Countermeasures: 1) Develop a protocol on interdepartmental referrals and collaboration, including a flow chart; 2) encourage effective 2-way communication at admission;
3) educate staff to share adequate information on patient care.

Results: Average number of patients exceeding bed capacity declined to 0 in August 2005.

Francistown Tebelopele VCT Center

Problem: During May and June 2005, 35% (533/1511) of intake sheets completed by counselors at the at the Francistown VCT Center had at least two errors, resulting in inaccurate information being sent to the data manager, thus affecting the quality of data sent to the National AIDS Control Administration.



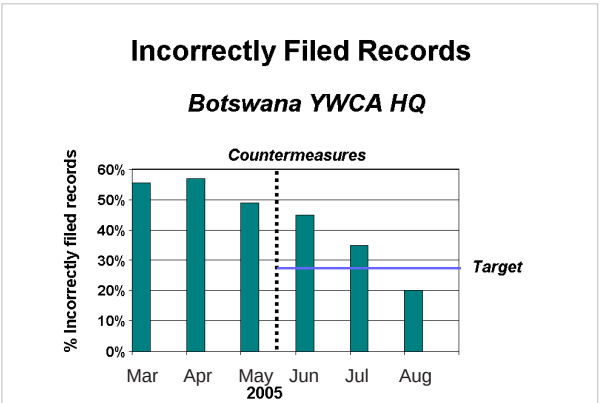
Improvement Target: Reduce the percentage of intake sheets containing errors in data collection to 20% during July and August 2005.

Countermeasures: 1) Review intake sheets, 2) develop a policy and a schedule for review, 3) clarify ambiguous areas on the intake sheets.

Results: The percentage of intake sheets with errors dropped to 15% (93/627) in July and to 24% (174/727) in August 2005.

Botswana Young Women's Christian Association (YWCA)

Problem: From March to May 2005, 54% (122/225) of the records at the YWCA headquarters were incorrectly filed, thus compromising management decision making.



Improvement Target: Reduce the percentage of incorrectly filed records from 54% to 27% by September 2005.

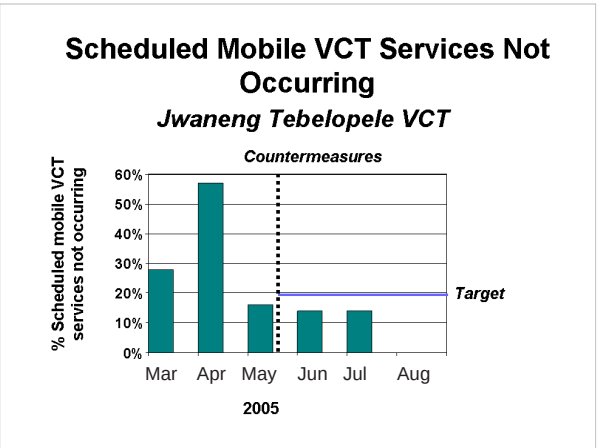
Countermeasures: 1) Develop an orientation and monitoring and evaluation plan, 2) train staff in record keeping, 3) provide motivational activities.

Results: The percent of incorrectly filed records fell to 45% in June, to 35% in July, and to 20% in August.

Jwaneng Tebelopele VCT Center

Problem: During the months of March–May 2005, 35% (7/20) of the planned mobile VCT services at Jwaneng Tebelopele did not take place, thus denying people access to VCT services and available programs.

Improvement Target: Decrease the percentage of planned mobile services not occurring from 35% to 20% during June–August 2005.



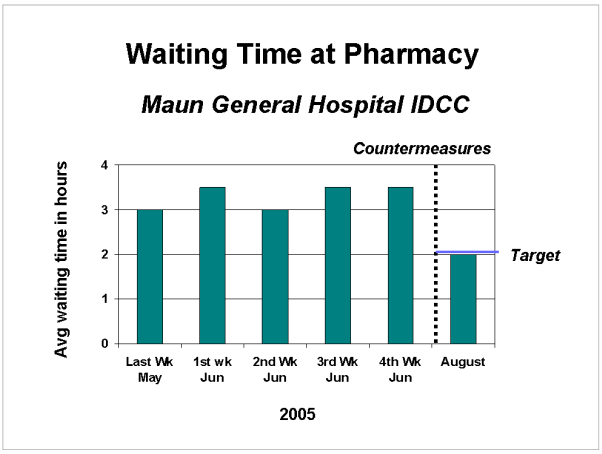
Countermeasure: Establish a clear communication network with other local organizations.

Results: The percent of planned mobile services not occurring dropped to 14% in June and July and to 0% in August.

Maun General Hospital

Problem: In the last week of May and the month of June 2005, patients at Maun General Hospital pharmacy waited an average of 3 hours before receiving services, thus increasing customer dissatisfaction and causing some to leave without their medication.

Improvement Target: Reduce patient waiting time by 1 hour (30%) by September 30, 2005.



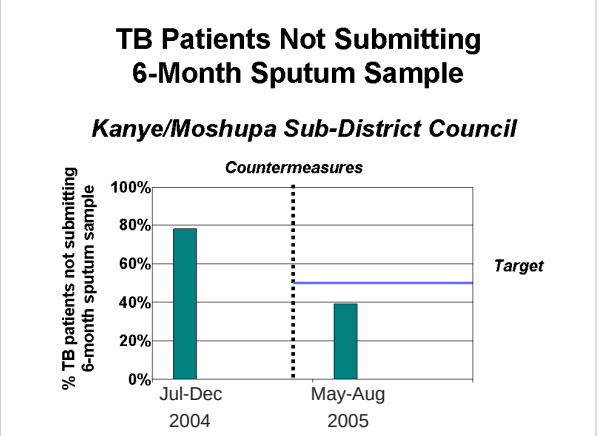
Countermeasure: Create an appointment schedule for the pharmacy.

Results: Waiting time was reduced to 2 hours during August 2005.

Kanye/Moshupa Sub-District Council

Problem: During July–December 2004, 78% (83/106) of tuberculosis patients in 5 clinics of Kanye/ Moshupa Sub-District did not have sputum collected at 6 months as prescribed by tuberculosis treatment protocol, thus resulting in possible spread of the disease.

Improvement Target: Decrease percentage of TB patients not having sputum collected from 78% to 50% during the period May–August 2005.

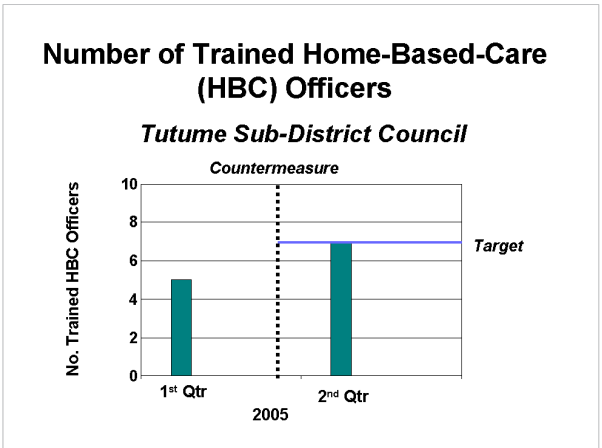


Countermeasures: 1) Educate patients about the importance of sputum testing at 6 months, 2) educate health workers on stock management to ensure adequate supplies of sputum bottles, 3) train health workers in TB testing.

Results: Percentage of TB patients not having sputum collected declined to 39% during May– August 2005.

Tutume Sub-District Council

Problem: In the first quarter of 2005, 56% (5/9) of home-based-care (HBC) Officers in the Tutume health catchment areas—Nata, Tutume, Sebina, and Tonota—lacked skills in mobilizing the community for action, resulting in absence of HBC societies and PLWA support groups, which in turn led to compromised quality of care to patients and an increased burden of care on care givers.



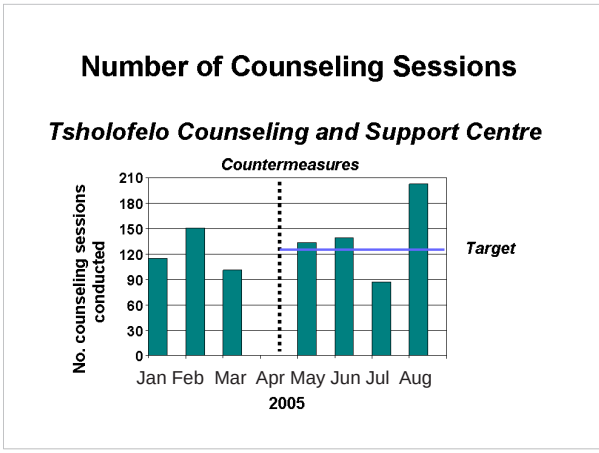
Improvement Target: 89% (7/9) of HBC officers will demonstrate skills in community mobilization by September 1, 2005.

Countermeasure: Train HBC officers.

Results: The target of 89% (7/9) HBC officers with demonstrated skills in community mobilization was reached in the second quarter 2005.

Tsholofelo Counseling and Support Centre

Problem: From January–March 2005, only 51% (366/720) of the expected counseling sessions were conducted by Tsholofelo Counseling Center in Lobatse, resulting in many clients struggling with emotional burdens and unable to make informed decisions for their lives.



Improvement Target: Increase the percentage of expected counseling sessions conducted to 71% for May, June, July, and August 2005.

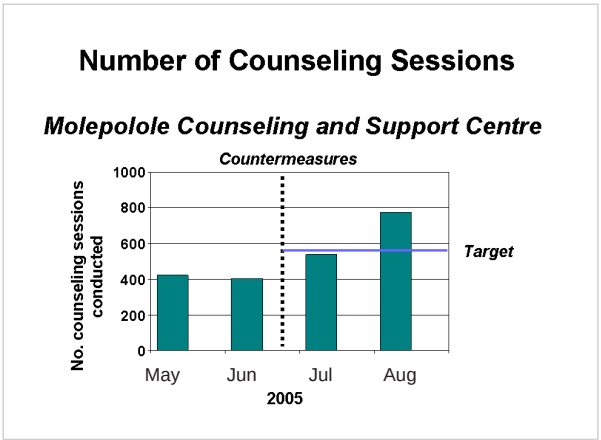
Countermeasures: 1) Counseling coordinators provide better supervision; 2) improve counselors' skills and appraise their performance.

Results: In August 2005, the target was exceeded—112% of the planned counseling sessions took place (202/180).

Molepolole Tebelopele VCT Center

Problem: In May and June 2005,client use of the Molepolole VCT averaged 440 of the anticipated 550 sessions per month (80%). Potential clients did not access potential HIV/AIDS programs, nor were they able to know their HIV status.

Improvement Target: Increase the average number of client sessions to the 550 target in August 2005.



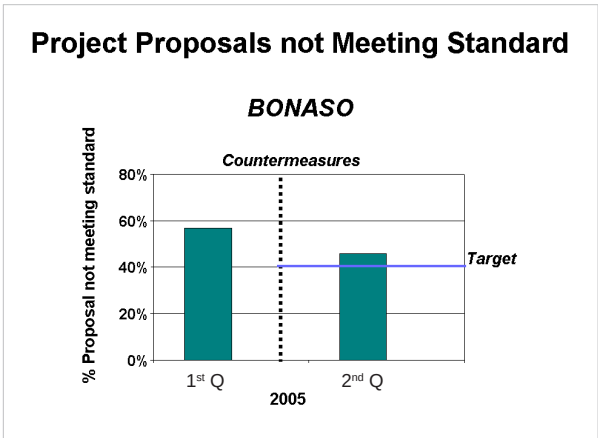
Countermeasure: Establish mobile counseling and visit clients where they live.

Results: In August, 773 counseling sessions were held, 223 more than the 550 target (40% better than expected).

Botswana Network of AIDS Service Organizations (BONASO)

Problem: During the first quarter of 2005, 57% of project proposals submitted by CBOs/NGOs to BONASO were rejected as not up to standard, thus denying the civil society access to the much-needed funds for health intervention programs.

Improvement Target: Reduce the percentage of rejected/deferred proposals to 40% during the second quarter of 2005.



Countermeasures: 1) Engage and educate District Multisectoral Aids Coordinators, CBOs, and NGOs on the grant application process; 2) develop project reporting toolkit.

Results: During April–June 2005, 46% (11/24) of the proposals were rejected as not up to standard.

Youth Health Organization (YOHO)

Problem: During the last two quarters of 2005, the YOHO board of Directors planned two meetings, but did not meet. The failure to meet resulted in ineffective management.

Improvement Target: Hold at least 1 meeting by August 2005.

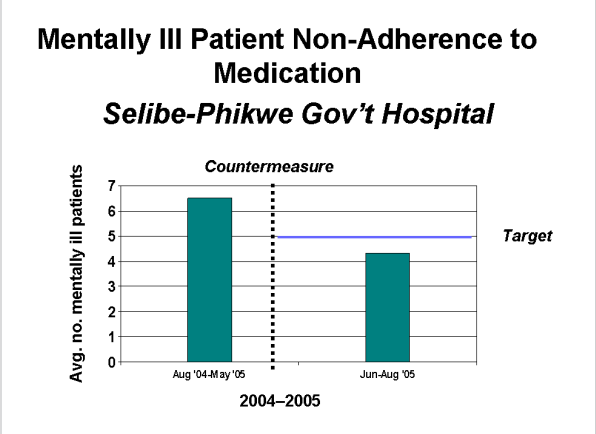
Countermeasure: Dissolve existing board, select new members, establish a meeting schedule, and appoint a convener.

Results: One meeting was held in 2005.

Selibe-Phikwe Government Hospital

Problem: From August 2004–May 2005, the averge number of mentally ill patients at Selebi-Phikwe Government Hospital and its catchment areas who had relapsed due to non-adherence to medication was 6.5 per month.

Improvement Target: Reduce the average number of patients relapsing per month due to non-adherence to medication to 5 during June–August 2005.



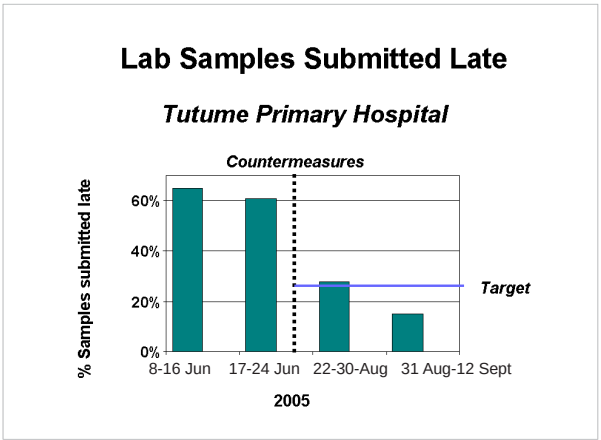
Countermeasures: 1) Disseminate information to the public to reduce stigma, 2) educate and train nurses, 3) hold a plenary informational meeting for mentally ill patients in the hospital.

Results: After the countermeasures were implemented, the average number of patients relapsing per month due to non-adherence was 4.3 during August 2005.

Tutume Primary Hospital

Problem: Between June 8–24, 64% (82/129) of clinics and wards submitted samples late, leading to late release of results, delaying review and treatment of patients.

Improvement Target: Reduce percentage of late sample submissions by clinics/wards to Tutume Primary Hospital Laboratory to 25% by December 9, 2005.

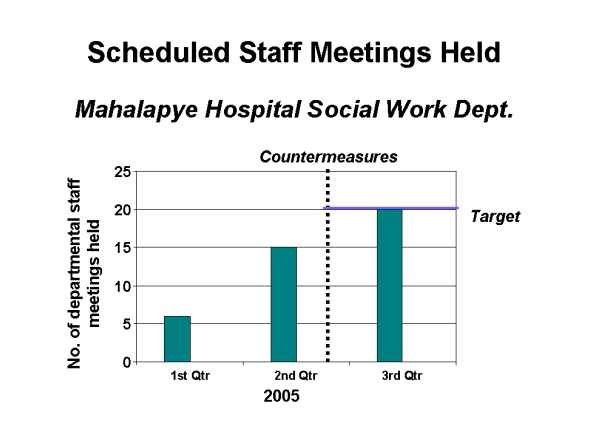


Countermeasures: 1) Disseminate information about samples to clinics and wards, 2) provide information to drivers on the need to bring samples to the laboratory early, 3) remind patients to come early to facilities.

Results: By mid-September 2005, late sample submissions to Tutume Primary Hospital Laboratory were reduced to 15%.

Mahalapye Hospital

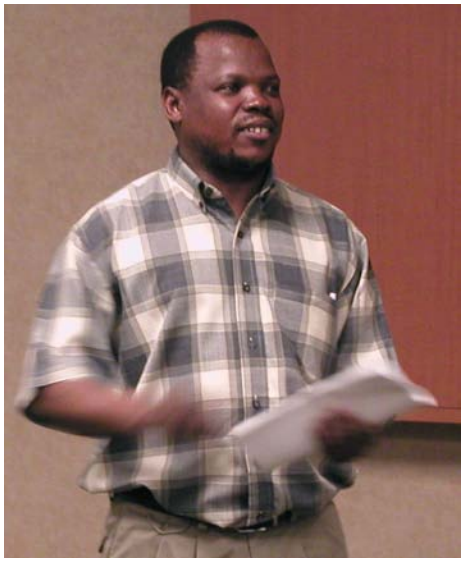
Problem: For the first 6 months of 2005, the Social Work Department at Mahalapye Hospital held only 23 of 48 (48%) of scheduled departmental staff meetings, thus depriving the staff an opportunity to improve counseling skills through case conferencing. This resulted in decreased quality of service and decreased customer satisfaction.



Improvement Target: Increase the number of scheduled departmental staff meetings held to 20 by September 8, 2005, and to 71 by the end of December 2005.

Countermeasures: 1) Assign one staff (on rotation) to attend to emergencies while others attend meetings; 2) display meeting schedule in strategic work areas; 3) sensitize and motivate staff on the importance of planning.

Results: By the end of September 2005, 20 meetings were held, thus meeting the initial improvement target.

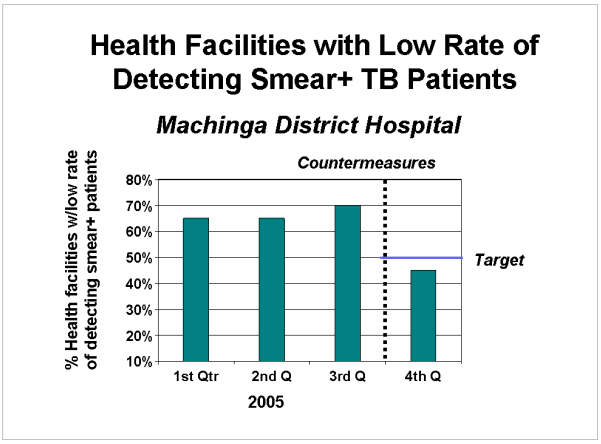


Mr. Tebasto Paul, Institute of Development Management, explains the training plan for Botswana during the MIPH 2004 course.

Machinga District Hospital

Problem: During the 1st quarter of 2005, 65% (11/17) of the health facilities in Machinga had a low case-detection rate of new smear-positive TB patients thereby leading to spread of TB in the community.

Improvement Target: Reduce the percentage of health facilities with low case detection rate of new smear-positive TB patients from 65% to 50% during the fourth Quarter of 2005.



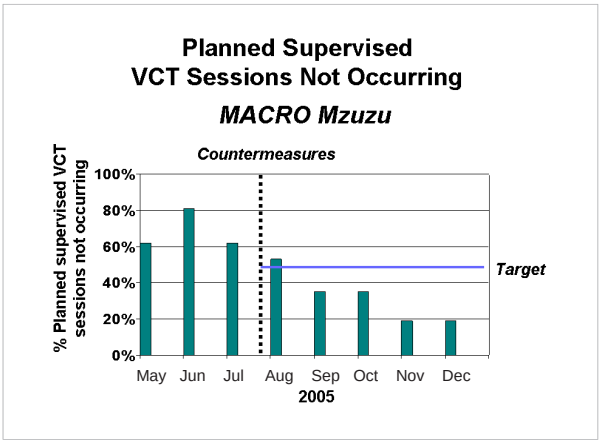
Countermeasures: 1) Orient clinicians on NTP guidelines and orient Health Surveillance Assistants on importance of Chronic Cough Register, 2) prioritize follow-up of trained traditional healers, and 3) reinforce IEC for health promotion.

Results: During the fourth quarter 2005, 47% (8/17) of the health facilities had low case-detection rates of smear-positive tuberculosis.

MACRO Mzuzu

Problem: During the first quarter of 2005, 70% (23/33) of planned counselor peer observations of VCT sessions were not conducted at the MACRO–Mzuzu branch, thus compromising the quality of VCT service delivery to clients.

Improvement Target: Decrease percentage of scheduled but unobserved VCT sessions to 50% between October and December 2005.

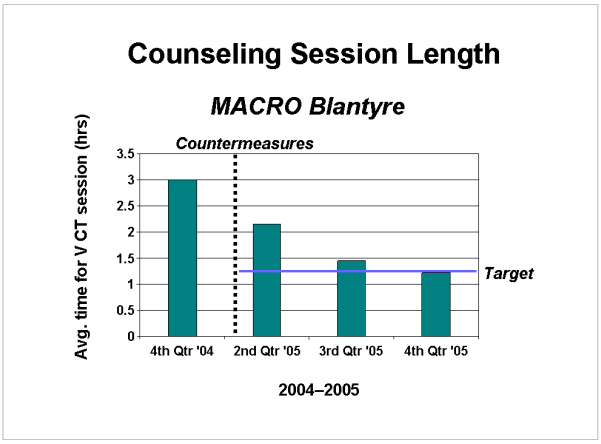


Countermeasures: 1) Brief counselors on the forms of supervision and importance of peer observation, 2) develop a quality conscience culture among counselors, 3) develop effective communication channels within the branch, and 4) have one deployment point.

Results: The percentage of unobserved sessions dropped from 70% to 24% (8/33) during the period October–December 2005.

MACRO Blantyre

Problem: During the fourth quarter of 2004, VCT clients at MACRO Blantyre took approximately 3 hours to undergo counseling and testing compared to the recommended 1 hour, 20 minutes, resulting in frustration and in many clients dropping out.



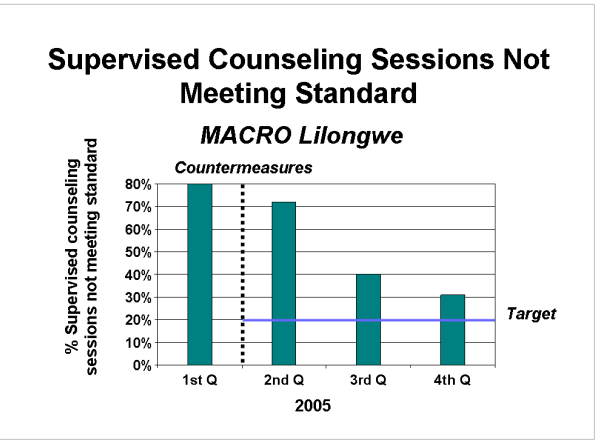
Improvement Target: Reduce the average time from 3 hours to 1 hour, 20 minutes during the fourth quarter of 2005.

Countermeasures: 1) Train counselors in customer care, 2) encourage management to develop a proper staff deployment system, and 3) create supervisory skill refresher courses for supervisors.

Results: The average time was reduced from 3 hours to 1 hour 22 minutes during the fourth quarter of 2005.

MACRO Lilongwe

Problem: During the first quarter of 2005 at MACRO Lilongwe Branch, 80% (12/15) of counseling supervision sessions did not meet standards—specifically, the sessions were not client-focused on risk assessment and risk reduction planning, resulting in clients being at continued risk of contracting HIV infection and infecting others.



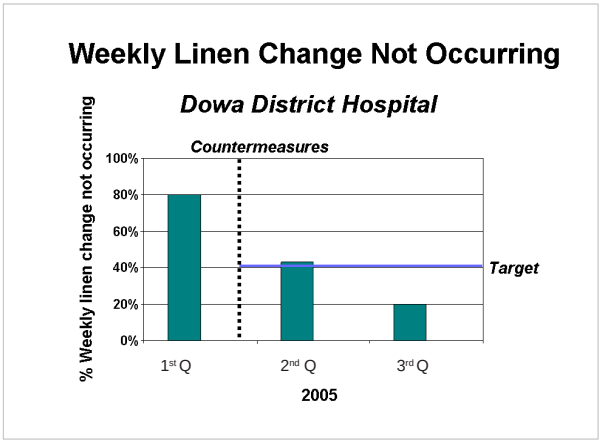
Improvement Target: Reduce the percentage of sessions not meeting standards from 80% to 20% from April–December 2005.

Countermeasures: 1) Strengthen interaction between senior counselors and management, 2) include VCT protocol message in promotional material/advertising, 3) orient counselors during supervision, and 4) establish a reward system.

Results: By the fourth quarter of 2005, the percentage of sessions not meeting standards had dropped to 31%.

Dowa District Hospital

Problem: In the first quarter of 2005 at Dowa District Hospital, scheduled weekly linen changes did not take place 80% (120/150) of the time, leading to probable nosocomial infections in patients.



Improvement Target: Reduce weekly linen changes not occurring by half—to 40% of the time—during the 3rd quarter of 2005.

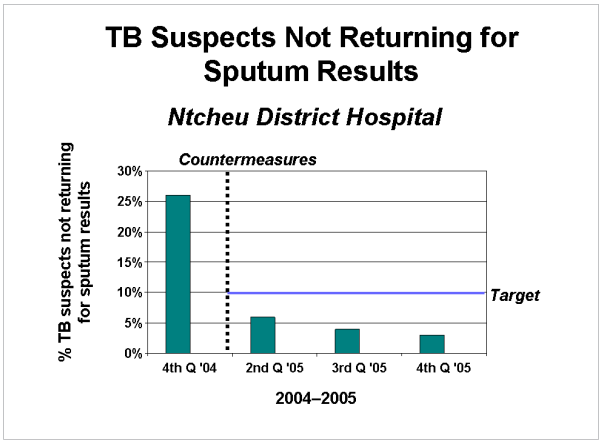
Countermeasures: 1) Identify a supervisor for laundry attendants, 2) keep laundry supplies in stock, 3) carry out quarterly Infection Prevention Control Committee (IPCC) Assessments, and 4) have procedure manuals in all departments.

Results: During the 3rd quarter of 2005, the percentage of weekly linen changes not occurring declined to 20% (30/150).

Ntcheu District Hospital

Problem: In the fourth quarter 2004, 26% (68/262) of TB suspects who submitted sputum for microscopy examination at Ntcheu District Hospital did not return to receive their smear results. This resulted in missed smear-positive cases and possible increased infection in the community.

Improvement Target: Reduce to 10% the TB suspects who do not return for their sputum smear results by the fourth quarter 2005.



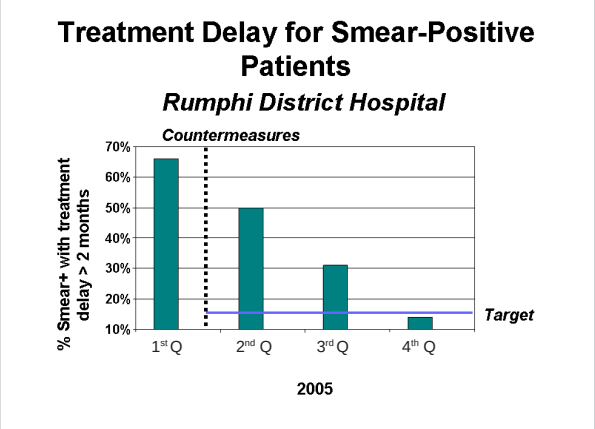
Countermeasures: 1) Orient various hospital staff on TB management and IEC, 2) sensitize communities and TB suspects on the need to return for their sputum results, 3) ask clinicians not to discharge patients who have not received their sputum results.

Results: During the fourth quarter 2005, fewer than 3% of patients failed to return for their sputum results.

Rumphi District Hospital

Problem: During the first quarter of 2005, 66% (19/29) of diagnosed smear-positive TB patients delayed seeking treatment for more than two months (8 weeks), resulting in continued spread of TB infection in the community.

Improvement Target: Reduce the percentage of patients delaying seeking TB treatment from 66% to 15% by the end of December 2005.

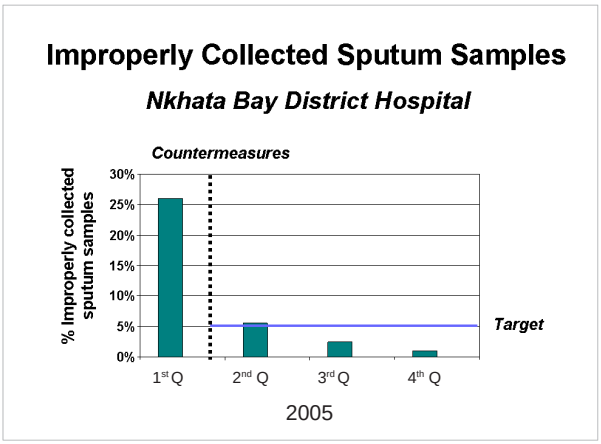


Countermeasures*:* 1) Provide information to community, 2) orient managers and drivers to seriousness of TB, 3) orient nurses to timely collection and submission of sputum samples, 4) create TB microscopic centers.

Results: In the fourth quarter of 2005, only 14% of smear-positive patients delayed seeking treatment for more than two months.

Nkhata Bay District Hospital

Problem: During the first quarter of 2005, 26% (90/345) of sputum specimens sent to the laboratory at Nkhata Bay District Hospital had been improperly collected (e.g., presence of saliva only – no sputum, empty container, insufficient amount of specimen), resulting in uncertain diagnoses and unsatisfactory services.



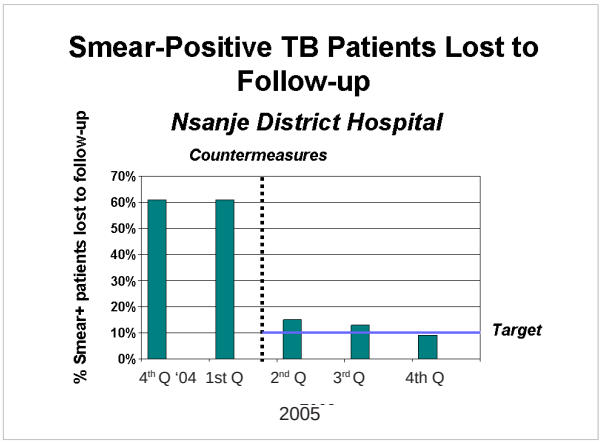
Improvement Target: Reduce from 26% to <5% the percentage of sputum specimens improperly collected by the end of the fourth quarter 2005.

Countermeasures: 1) Orient health workers in techniques of sputum collection, 2) educate patients concerning producing sputum samples, and 3) orient health workers in planning their work to include health education to patients.

Results: By the end of the fourth quarter 2005, the percentage of improperly collected sputum samples dropped to 1%.

Nsanje District Hospital

Problem: During the fourth quarter of 2004, 61% of sputum positive patients on TB treatment were not followed up according to NTP guidelines, resulting in 1) uncertainty as to whether the patients were taking their medication and 2) a low cure rate.



Improvement Target: Reduce the percentage of sputum-positive patients lost to follow-up from 61% to 10% by the end of the fourth quarter 2005.

Countermeasures: 1) Allocate resources and time to orient health workers on the importance of follow-up for TB patients, 2) assign staff to orient drivers on the importance of collecting specimens from health centres and prompt delivery to district laboratory, 3) supervise health workers and provide feedback on their performance.

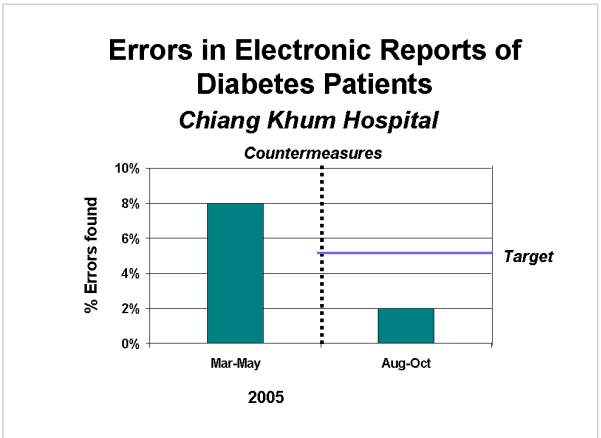
Results: By the end of the fourth quarter 2005, the percentage of sputum positive patients lost to follow-up dropped to 9%.

Mr. Leo Dambe, Regional TB Control Office (Mzuzu) and Mrs. Fannie Kachale, Kamuzu Central Hospital (Lilongwe) share a lighthearted moment after presenting their new management training plan during the MIPH 2005 course.

Chiang Khum Hospital

Problem: During March–May 2005, there were >7% errors found in electronic records of diabetes patients in the outpatient department, resulting in inaccurate lab results supplied to the patients.

Improvement target: Errors in electronic records for diabetes patients will drop to at most 5% during August–October 2005.



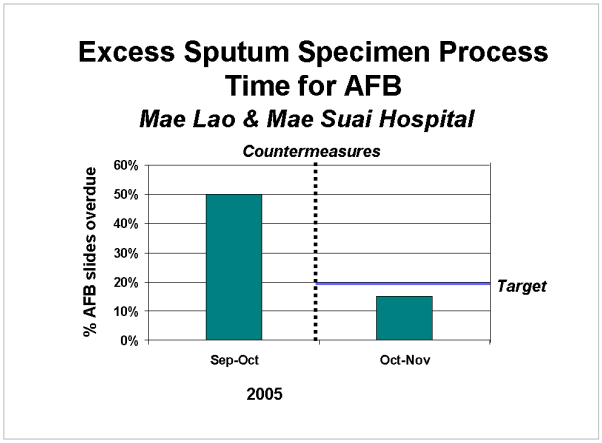
Countermeasures: 1) Provide more knowledge and skills in main technical area, 2) coach on network maintenance and random check all entries regularly for accuracy; 3) follow work instruction strictly.

Results: Reporting errors dropped to <2% during August–October 2005.

Mae Lao & Mae Suai Hospital

Problem: Thirty of 60 sputum specimens (50%) performed for AFB examination exceeded the 40-minute processing time standard at Mae Suai laboratory during September–October 2005.

Improvement target: Reduce percent of specimens exceeding the time standard to 20% by October–November 2005.



Countermeasures: 1) Provide a refresher training course to all lab staff, 2) analyze the workload of each laboratory staff person, 3) develop an evaluation tool to monitor and evaluate project activities.

Results: Only 16% (12/75) of sputum samples exceeded the standard processing time during October–November 2005.

National Institute of Health

Problem: In August 2005, 22% (433/1973) of Rickettsia Laboratory reports were delayed, resulting in clients waiting too long to receive those reports.

Improvement Target: Decrease delayed reports to < 5% by February 2006.

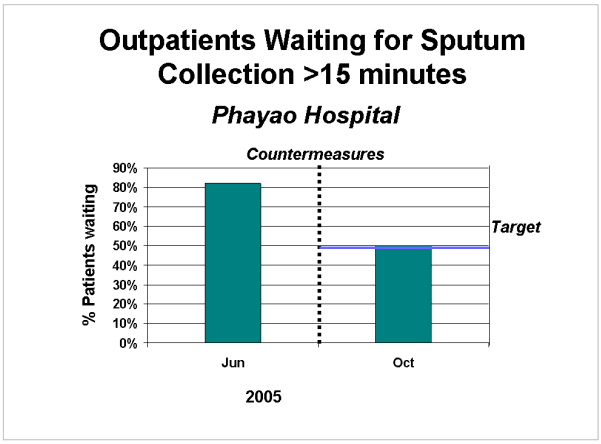
Countermeasures: 1) Organize a meeting to revise routine practice and 2) assign authorized person(s) to be a representative to lab supervisor for report approval.

Results: No reports were delayed after 1-month implementation of countermeasures.

Phayao Hospital

Problem: During June 2005, 82% of outpatients waited longer than 15 minutes for collection of their specimens, resulting in patient dissatisfaction and delays in treatment.

Improvement target: Reduce percentage of out-patients waiting longer than 15 minutes for specimen collection from 82% to < 50% by October 2005.



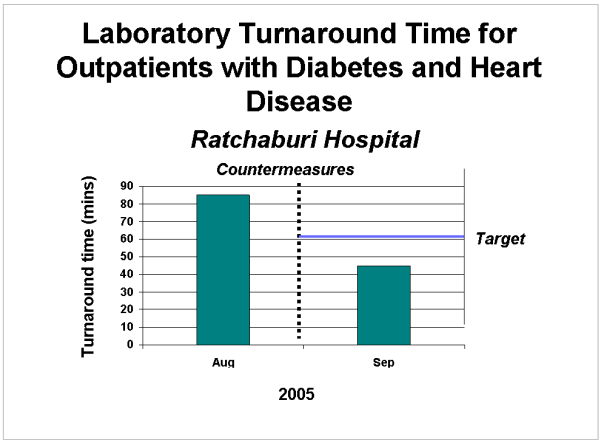
Countermeasures: 1) Re-classify patients by their laboratory requisition by test type, 2) add extra lab personnel to assist at peak times, 3) lab supervisor must monitor closely during peak times, 4) set up agreement to find practical methods for specimen management with outpatient department (OPD) staff at each OPD clinic.

Results: Percentage of outpatients waiting longer than 15 minutes decreased to 49% in October.

Ratchaburi Hospital

Problem: In June 2005, the average out-patient laboratory turnaround time was 85 minutes for diabetes mellitus and heart disease patients, resulting in customer complaints and dissatisfaction.

Improvement Target: Reduce the average out-patient laboratory turnaround time for diabetes mellitus and heart disease patients from 85 minutes to 60 minutes or less for a one-month period by September 2005.



Countermeasures: 1) Change routine work process at the outpatient department by providing sequential numbers to patients after their specimen collection; 2) request new equipment for blood chemistry analysis (sugar and HDL).

Results: The average laboratory turnaround time after implementation of countermeasures was reduced by 45%, to 46 minutes.

Appendix D

MIPH Graduates in Eight GAP Countries

Botswana
Mrs. Rose Lebang Choto (’05)*
Ms. Audrey Kgosidintsi (’00)
Mr. Modisaotsile Mokomane (’03)*
Mr. Ronald Molosiwa (’01)*
Ms. Kgomotso More (’00)
Mr. Martin Seike Mosima (’01)*
Mr. Tebatso Paul (’04)*
Mrs. Othilia Tjawada Phumaphi (’02)*

Haiti
Mr. Gregory Desir (’05)*
Dr. Yves Gaston DesLouches (’04)*
Mr. Patrice Nevil (’05)*
Ms. Claudia Thomas Riche (’04)*

India
Dr. Raja Bharti (’93)
Mr. Stanley Joseph (’04)*
Dr. Sudhir Joshi (’93)
Mr. Keerti Bhusan Pradhan (’01)*
Mr. Ramachandran Prakash (’93)
Dr. Mala Ramachandran (’98)
Dr. Govada Mastan Rao (’98)
Mr. Jacob Varghese (’04)*

Malawi
Mrs. Rhoda Patricia Banda (’02)*
Ms. Theresa Banda (’93)
Mrs. Felesia Samuel Chawani (’05)*
Mr. Wright James Chisamba (’03)*
Mr. Isaias Leo Dambe (’05)*
Mr. Andrew D.R.C. Dimba (’03)*
Mrs. Fannie Kachale (’05)*
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